Teen suicide

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TEEN SUICIDE

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TEEN SUICIDE

INTRODUCTION

Major increases took place in Canadian suicide rates in the 1960s and 1970s and, while they have levelled out in the 1980s, they are still at the highest level in Canadian history. Between 1960 and 1978, the overall suicide rate rose from 7.6 per 100,000 population to 14.8, according to Statistics Canada figures. During the last decade, the suicide rate, though relatively stable, has been about double the rate throughout most of the period from 1921 to 1961. It has remained well above previous highs recorded during the Depression of the 1930s. It is important to remember that the actual number of suicides in Canada may be under-reported. A death is only certified as a suicide by medical and legal authorities when the victim's intent is clearly proven.

The federal government moved to address the suicide problem by appointing a National Task Force on Suicide in Canada in 1980. Its report was made public in 1987. While the statistics used are from 1985 at the latest and more often earlier, the study is the most comprehensive examination of the phenomenon ever done in Canada. Seven population groups were identified by the Task Force as being at high risk; one of these was young people. While males aged 20-24 are the age group which has seen the most significant rise in suicide deaths in the past 20 years, marked increases have been noted in the 15-19 age group, again most significantly among males. The report describes and evaluates a range of prevention, intervention and follow-up programs, and makes a number of recommendations having to do not only with the determinants of suicide but with the means of preventing it. No major federal policy initiatives have resulted from the report. It is not the intention of this paper to review the findings

of the Task Force report but rather to comment on changes in dealing with certain aspects of the teenage suicide phenomenon, changes found since the Task Force's research was done and drawn primarily from periodical sources published since 1987.

Though the rates are higher in Canada than in the United States, Canadian statistical trends for suicide correspond for the most part with American statistics; therefore some American studies will be used in this paper in an attempt to focus more precisely on the suicide phenomenon among teenagers.

A. Looking for Reasons

There are no definitive explanations of why more teenagers these days are committing suicide than ever before. Suicide is a multi-dimensional behaviour and difficult to define in any essential way.

The foremost theoretian on suicide, Emile Durkheim, defined three types of suicide. The first is altruistic suicide, where the individual is so closely integrated into a group or society that he or she will commit suicide for the benefit of the group. Examples would be the Japanese kamikaze pilots of World War II and the mass suicide at Jonestown.

The second type is egoistic suicide; this is characterized by a strong value system, weak group integration and an overpowering sense of personal responsibility. The group itself is not strong enough to provide the individual with a sufficient source of support and strength outside him or herself. Nor is the society sufficiently integrated to be able collectively to mitigate the individual's feeling of responsibility and guilt for moral weaknesses and failure.

The third type of suicide identified by Durkheim is not characterized by a strong value system. Anomic suicide results from not being properly integrated into a system of cultural values and thus seeing social norms as meaningless. The characteristic feelings of isolation, loneliness and personal confusion noted in this type of suicide are often brought on by a major disruption in one's way of life, such as the death of a parent or a move to a new home far from one's friends.

One would think anomic suicide provided the best explanation for the phenomenon of teenage suicide, as it hinges on experiences closely associated with adolescence. Subtle distinctions, however, exist.

1. Gender Differences

Being male has been found to raise the odds of suicide in Canada no matter what the age group. It should be noted, however, that maleness is only significant in terms of completed suicide. Parasuicide (attempted suicide) is up to three times as common among females as males. The number of suicide attempts are as many as ten times the number of deaths but males are six times as likely to die of suicide as females. This has been found to be a cross-cultural phenomenon.

Psychologist Antoon Leenaars, president of the Canadian Association for Suicide Prevention, says the reasons are more sociological than psychological.(1) He explains that males are socialized to hide their feelings and deny pain if they are "to be a man." This emphasizes a feeling of personal responsibility for not fitting into the dominant male culture. Male culture places no blatant emphasis on mutual support at the adolescent stage, but rather thrives on competition. It is a culture, too, which has been weakened by the sexual revolution and is in the process of change. These factors illustrate the fact that for young males, suicidal impulses have more to do with Durkheim's egoistic model than the anomic model.

Females, on the other hand, tend to follow the anomic model. In studies carried out to determine why teenage girls and women account for so many suicide attempts and yet so few suicide deaths, theorists have gone much further than Durkheim. Self-in-relation theory, used to look at females and depression, is helpful in illuminating gender differences in suicidal behaviour. Current literature shows a consistent pattern linking the primacy that females place on relationships with

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(1) Burt Dowsett, "Young Men, Senior Males Form Most Suicidal Groups," in London Free Press, 12 June 1990.

factors influencing suicidal behaviour. Stress resulting from an inability to deal with interpersonal conflicts is more often a factor among females than males. This theory focuses on four common processes which, when exaggerated, underlie women's suicidal attempts: the concepts of vulnerability to loss, inhibition of anger, inhibition of action and aggression and low self-esteem. Rather than perceiving these as weaknesses, as in traditional theory which views the male experience as the norm, self-in-relation theory looks at these behaviours as sources of strength based on a female norm. By examining the normative experience of females, greater understanding of the gender differences in suicidal behavior is emerging.

Another theory used to explain the gender differences in suicide attempts and completions hinges on the methods of attempted suicide used. Teenage girls tend most often to use drugs while boys use more instantaneously lethal methods like firearms. Such differences are changing, according to American sources. The Centers for Disease Control noted that in 1970 fewer than one-third of the suicides by women aged 15 to 24 were carried out with a firearm, while in 1984 this was the case for a little more than half of the suicides by women in that age group. And while in 1970 42 per cent of the young women who killed themselves used drugs, by 1984 this percentage had dropped to 19 per cent. Sociologist James Mercy expects these trends to continue because of the easy availability of firearms in the United States and the increasing difficulty of obtaining lethal types of barbiturates.(2)

A controversial theory to explain the gender difference has been put forward by psychologist Lee Salk of Cornell University Medical School; this draws a link between birth trauma and later suicide. He pointed out the fact that infant mortality rates began dropping substantially around fifteen years before teenage suicide rates began escalating. He pointed out that male babies suffer from more birth complications than females and went on to document the three common denominators that turned up repeatedly among the suicides: respiratory distress for over one hour at birth, lack of prenatal care before the twentieth week of pregnancy, and

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(2) Judy Folkenberg, "Guns and Gals," in Psychology Today, July/August 1988.

chronic ill health of the mother during her pregnancy. He even went so far as to demonstrate a correlation between methods used in suicide attempts and the type of intervention used at birth.

This hypothesis was also pursued by doctors in Sweden who found that suicide was more closely associated with birth trauma than with any other of the 11 risk factors for which they tested, including such socioeconomic variables as parental alcoholism and broken homes. This theory continues to be very controversial among the medical community which aims at increasing obstetrical control and intervention rather than decreasing it as these scientists advocate.

2. Cultural Differences: Comparison with the United States

A recent comparison of suicide rates in the U.S. and Canada found that the teen suicide rate among Canadian males is 57 per cent higher than in the United States. Antoon Leenaars of the Canadian Association for Suicide Prevention attributes this to the cultural theory that says Canadians are more repressed than Americans since Canada, as a colony, was founded on the British values of Queen and religion while the United States, on the other hand, was built by brash, aggressive, gun-toting pioneers, who fought their way westward and crushed all obstacles in their path. "Because of that," says Leenaars, "it has been suggested that in the U.S. they kill each other. In Canada we kill ourselves."(3) While simplistic on its own, Dr. Leenaars' observations highlight a cultural dimension to suicide behaviour that can be useful in prevention techniques, as will be discussed later with respect to native peoples.

3. Cultural Differences: Quebec

Quebec has the highest rate of teen suicides of all the Canadian provinces and has also one of the highest rates in the world.

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(3) "Teen Suicide," in Windsor Star, 7 April 1990.

Dr. Mounir Samy, founder and director of Montreal General Hospital's adolescent crisis intervention team, argues that the social upheaval in Quebec since the 1960s affects troubled teenagers by giving them nothing stable to fall back on. He points to the Quiet Revolution and to family breakdown as key reasons. "Another contributor, Samy says, is the "suicide option" our society offers. "We are a society that values the quality of life rather than its quantity...Life is [seen by some teenagers as] not worth living if you cannot guarantee its quality."(4) The cultural aspect of suicide behaviour can be examined both broadly and specifically. While it illustrates only part of the picture, it is nonetheless an essential aspect to be looked at in the search for effective solutions.

4. Suicide Clusters

While the increase in suicides has levelled out in recent years, the number of "cluster suicides" is on the increase. The existence of suicide clusters is an aspect of the suicide phenomenon which has focused public attention recently on teenage suicide in Canada. In Lethbridge, Alberta, three youths committed suicide within three months of each other and a similar tragedy occurred in Antigonish, Nova Scotia. While some people suspected Satanic cult influences in the Lethbridge case, there has been no substantial evidence that such influences were a factor. Teenagers themselves say media focus on this possibility or on the influence of heavy metal music or music videos are just attempts by adults to relieve their own guilt feelings and not to listen to the real problems teens are facing. Whether there were suicide pacts or not, the incidence of copycat suicides among teenagers is becoming all too common throughout the world. Reasons for this new development are inconclusive. But it is safe to say that young people who do not find solutions to their problems from family, doctors or teachers, look to their peers for assistance.

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(4) "Teen Suicide Rate Linked to Quiet Revolution," in Montreal Gazette, 13 May 1988.

Even if teenagers do not attempt suicide, some studies say half of all teenagers think about it. Simon Davidson, Director of Psychiatric Research at the Children's Hospital of Eastern Ontario, released a report earlier this year making this claim. Dan Wiseman, head of social services for the Ottawa Board of Education, believes the finding could very well be true but noted that only 10 to 12 per cent of those students actually attempt suicide while only one to two per cent die. Wiseman, who helped implement the Ottawa Board's in-house teen suicide prevention program, says that because teenagers lack experience in solving problems and dealing with stress, suicide becomes a viable alternative.(5)

B. Prevention

1. Recognizing the Symptoms

According to the London/Middlesex branch of the Canadian Mental Health Association, which has been very active in teen suicide prevention programs, there are several warning signs of suicidal intent: depression; statements that show a preoccupation with dying; drastic behaviour or mood swings; lack of interest in future plans; making final plans; previous attempts (80 per cent of people who kill themselves have tried it before); sudden improvement after a period of depression; and self-destructive behaviour.(6)

Anxiety, isolation, depression, drug abuse, delinquency and family breakdown can all be implicated, either separately or in combination. The importance of family relations is noted by American therapists who point out that family therapy is on the decline. Parents increasingly do not wish to be involved in the therapy of their children.

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(5) John Ibbitson, "Experts Rap Report on Teen Suicide," in Ottawa Citizen, 17 January 1989.

(6) Burt Dowsett, "Suicide: Recognizing the Symptoms," in The London Free Press, 12 June 1990. The death of a parent, particularly a mother, increases the risk of a suicide attempt 600 times.

Eighty per cent of teenagers who eventually attempt suicide show up at a doctor's office before they try it. The teenagers complain of symptoms that should sound alarm bells but are usually missed by the doctor. These teenagers may complain of insomnia or fatigue or problems at school, but the underlying cause is not being picked up.(7) This has led the focus of prevention techniques away from the family unit and the medical profession and toward the schools.

2. Strategies That Work

Bruce Connell, a consulting psychologist for the Board of Education in London, Ontario, concludes from his survey of the literature on the subject of teen suicide that 95 to 97 per cent of suicides could be prevented.(8)

Frank Trovato's study of the effects of age, period and cohort examined Canadian statistics from 1921-25 to 1981-85.(9) It concludes that divorce and urbanization show significant "positive" effects on the likelihood of committing suicide, while the effect of religious secularization, although present, failed to reach statistical significance.

Trovato's study confirms that examining age, period and cohort indicates that suicide is mainly an age-specific phenomenon and that period and cohort are of limited relevance for the substantive understanding of this phenomenon in Canadian society.

In the search for prevention techniques through the school system, Dr. Barry Garfinkel, director of child and adolescent psychiatry at the University of Minnesota, designed questionnaires to elicit information on depression and has administered them to 15,000 students annually for

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(7) Richard Sutherland, "Teenage Suicide Epidemic in Canada," in The Financial Post, 22 February 1990.

(8) Dowsett, "Suicide: Recognizing the Symptoms" (1990).

(9) Frank Trovato, "Suicide in Canada: A Further Look at the Effects of Age, Period and Cohort," in Canadian Journal of Public Health, Vol. 79, No. 1, January/February 1988.

several years. Anyone scoring positive on the questionnaire is sent to a guidance counsellor or school psychologist. This method has gained approval in Canada, specifically in Quebec where the problem of teenage suicide is particularly acute.

Another successful tool has been peer-group discussion groups. Particularly in view of the rise in "copycat" or suicide clusters, this method is seen as a crucial aspect of prevention. When a suicide occurred at A.B. Lucas Secondary School in London in October 1987, the student's friends and a guidance teacher formed a Breakfast Club to focus some of their grief into positive programs that would help future students. The club has grown to 260 students and branched out into orientation programs for Grade 8 students in order to make the transition from junior high to high school less traumatic.

For more effective program planning and management at suicide prevention centres, the Greater Vancouver Mental Health Service uses a computer information system which has evolved over the past ten years. Designed with the input of counsellors, researchers, community agencies, a clinical consultant and other professionals, the system is reviewed annually. It was designed to meet the practical needs of ongoing counselling activity as well as long-term planning and evaluation needs. Information collected is published in report form and used in public education activities. It should be noted that confidentiality is built into the system.

The National Task Force Report of 1987 included a proposed educational program for school personnel and students; model suicide intervention services for hospitals, communities and Native people; and an Alberta model for a systematic approach to suicide prevention. The Appendices to this paper give excerpts from the Task Force Report and relevant statistical tables.

3. Culturally Specific Approaches: Natives

Another identifiable risk group is made up of Native Canadians. The incidence of suicide specifically among Native teenagers

(not among all age groups) is often ten times that among their white counterparts. While it is not within the scope of this paper to examine the Native situation in detail, it is worth noting the success of culturally specific prevention methods used in some communities.

Just as suicide in Native communities is a distinct phenomenon, so are the methods these communities use to deal with it. The difference between non-Native and Native approaches to education and prevention is that non-Native methods tend to rely on facts, while Natives use story-telling as a means of giving information about suicide. The technique was demonstrated in an internationally acclaimed radio program called "Kill the Feelings First," developed by George Tuccaru, a Native employee of CBC North in Yellowknife. In this program, stories stimulate the audience to examine various questions in the search for resources with which to cope. The challenge to mental health service planners in Canada is threefold: Are they willing to look at Native cultural health processes as good resources for mental health? Will they trust Natives to develop their own methods and approaches? Will they be able to see Native mental health from a spiritual, though not necessarily religious, perspective? The National Task Force on Suicide in Canada recommended that prevention strategies for Canadian Native peoples should be culturally oriented.

Native teenagers in Grande Cache, Alberta, formed a peer support group following the suicide of a 16-year old Native youth who had lived in a number of white foster homes since the age of nine.(10) Native community leaders saw this initiative as an important first step but stressed the need to improve family communication and to deal with the problems of alcoholism, violence and sexual abuse found in many Native families.

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(10) Gerry, Gee. "Teens Meet Suicide Issue Head On," in Windspeaker, 28 July 1989, p. 13.

CONCLUSION

Suicide has been related to lack of social integration, feelings of "alienation" in the population, transience, and rapid changes in values, income and lifestyle. Poor job prospects, families in a state of flux, changing social and moral values could all contribute to high youth suicide rates in the population as a whole. It is important to realize that suicidal behaviour is not necessarily linked to mental health problems. Nor, among suicidal teenagers themselves, are unemployment or alcoholism widespread problems.

While the reasons for suicide are complex and difficult to define, the experience of adolescence highlights unique problems for this high-risk age group. Author Marion Crook interviewed a number of teenagers in British Columbia who had attempted suicide. Common denominators that emerged were problems in their family situation and low self-esteem. Also apparent was the fact that the teens had not been helped in their contact with teachers, doctors or other professionals. The pressure to excel, perpetuated not only by parents and peers, pervades television programming and commercial advertising and was found to add to the anxiety of adolescence. Coping skills and sympathetic assistance in dealing with these problems are essential. Whether that comes from parents, teachers, doctors, other teenagers or television is not the issue. That such assistance come from somewhere is essential. The complexity of the issue must not inhibit community or government agency efforts to deal with a problem that is responsible for more adolescent deaths in Canada than anything else except accidents.

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